DOCUMENT RESUME

ED 256 973 CG 018 195

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TITLE Integrating Counseling and Human Development: The Example of Adolescence.
PUB DATE Apr 84
NOTE 17p.; Vice-Presidential address for Division E (Counseling and Human Development) presented at the Annual Meeting of the American Educational Research Association (68th, New Orleans, LA, April 23-27, 1984).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adolescent Development; Adolescents; Coping; *Counseling; *Individual Development; *Interprofessional Relationship; *Research Needs; Stress Variables

ABSTRACT

Division E of the American Educational Research Association is concerned with counseling and human development, yet these two components often appear to be poorly integrated. The integration of counseling and human development, however, is important both for scientific advance and for the provision of better service. A major goal for both counseling and human development is to help people live better, more satisfying lives. Both kinds of research focus on change processes, use the individual as the unit of analysis, and examine similar kinds of phenomena. Counseling research focuses primarily on change through intervention whereas human development research typically involves observation of naturally-occurring changes. These two ways of understanding human experience can be seen as complementary and interrelated. The development of a peer model program to reduce repeat pregnancy among adolescents benefited from information from both counseling and human development research. Collaboration between counseling and human development professionals could also be beneficial in dealing with adolescent eating disorders (bulimia, anorexia nervosa) and with adolescent stress and coping. Information from these two kinds of research is reciprocally informative and, in some cases, information from both sources is essential to the understanding of phenomena and to the improvement of human lives. (NRB)

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Integrating Counseling and Human Development: The Example of Adolescence

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Vice-Presidential Address for Division E (Counseling and Human Development) at the 1984 annual meeting of the American Educational Research Association, New Orleans, April, 1984.

Counseling and Human Development. That's the name for Division E. Have you ever wondered why these two areas are combined in this Division? I have and that's what I'm going to talk about today.

This was not the first AERA division that I joined, but I became interested in this Division as an appropriate one to which to submit papers and symposia. When I became interested in the Division for its professional affiliation possibilities, I heard repeatedly that a big issue was the feeling that the two components--counseling and human development--were poorly integrated, and perhaps even competitive and divisive.

Since that situation, assuming that it existed or exists, didn't seem like a satisfactory, constructive one to me, I have had, as a major goal of my vice-presidency, the integration of these components. My objective in this presentation is to discuss why this is a worthy goal. To do this, I will provide a bit of an historical perspective and then focus on why the integration of these two fields is important both for scientific advance and for the provision of better service. Finally, I will discuss ways to enhance integration, some that I've attempted and some that might be tried.

The History of Division E

Since there don't seem to be any Division archives--what would our colleagues in the history division think of that?--I consulted

with Bill Russell, Executive Officer of AERA, about any Divisional records in the central office. I was hoping to find clues as to the initial rationale for this organization of the Division. He found almost nothing but thought that all of the original divisions, of which we were one, were created to replicate the organization of most education schools. Whether that was the rationale, and whether it was accurate, I cannot determine. It does not replicate the structure at Penn State, for example, where counseling and human development are in different colleges. What we do know about Division E history is that the divisional structure was created in 1964, with Dale Harris as our first vice-president. I note, as an aside, that this would mean we are in 1984 celebrating our 20th anniversary.

The list of Division E vice-presidents include: Dale Harris (1964-66); John Krumboltz (1966-68); T. Antoinette Ryan (1968-70); (who?) (1970-72); Robert B. Winborn (1972-74); Carl Thoresen (1974-76); Barbara Varenhorst (1976-78); John J. Horan (1978-80); William E. Stilwell (1980-82); Anne C. Petersen (1982-84). As far as I can determine, I am the first of these ten VPs whose primary interest is in human development rather than counseling, although I know that some of the previous VPs were interested in both areas.

The only piece of correspondence in the AERA files was a complaint lodged in 1974 about the lack of human development sessions on the program. The VP at that time assured the writer

that if there was an imbalance in the program, it was due to the nature of submissions rather than any discriminatory practices in the program review process. Nevertheless, the writer was assured that the next program committee would be alerted to the concern.

This historical foray, albeit a superficial one, is not very illuminating. What little evidence that exists does support the perspective that integration, or even some balance of the counseling and human development needs, has been rather elusive. Perhaps there is a message in the historical record. Perhaps this combination is inappropriate. As you already know, this is not my perspective. I do think that the combination makes sense. I also think that more active efforts are needed to at least test the hypothesis that the integration of these perspectives will be beneficial to both these fields. So let me get on with the argument.

Integrating Counseling and Human Development

A major goal of counseling is typically to help people live better, more satisfying lives. Counseling research, then, would focus on ways to do this. A focus on human development typically involves the same goal as stated above for counseling: that is, an interest in helping people live better, more satisfying lives. Human development research, however, usually focuses on understanding <u>how</u> development proceeds, under various conditions (e.g., variations in family structure, peer groups, etc.). Both kinds of research focus on change processes; counseling research does this through planned change or interventions whereas

developmental research involves the examination of change under conditions that occur "naturally." Some other similarities in these two kinds of research are (1) the usual focus on the individual as the unit of analysis (although both areas often focus on interpersonal relationships and the broader social context as well) and (2) the kind of phenomena studied. In both areas of research, particularly in the educational context, the focus is on attitudes, thoughts, feelings, and behaviors, with some attention in both fields to change on the biological level as well.

Now I must acknowledge that I have "stacked the deck" a bit in my definitions to emphasize the similarities in the goals, focus, and methods of counseling and human development research. I have not exhaustively included everything considered in these two domains. But I suspect that disagreements would be minor and that we could get experts from the two fields to agree that the goals of our enterprises are basically similar and that our research focuses on human experience in some similar ways. As noted, however, there is a difference in approach. Counseling research focuses primarily on change through intervention whereas human development research typically involves observation of "naturally-occurring" changes. But these two ways of understanding human experience can be seen as complementary, and importantly interrelated.

One important difference in our fields historically, and one that I have not mentioned yet, is the age groups on which we focus. Counseling, especially in the education context, has probably

focused more on older than on younger students. Human development as a field began as child development. Indeed, it is interesting that in 1964, prior to the emphasis on life span development, our colleagues had the foresight to name this division human development rather than child development. Both fields have probably expanded their focus upward in age, as our society has become older.

The Example of Research on Adolescence

To further develop my argument of the essential complementarity of counseling and human development, I will use research on a specific age group: adolescence. (Just to pick a topic at random!) As some of you know, my research has focused on adolescent development. The work would be classified primarily as human development research but I have also done one intervention study using techniques borrowed from my counseling colleagues. I'd like to tell you the story of how I came to borrow these techniques and the benefits that this collaboration had for my understanding of adolescent development.

The story begins at AERA six years ago. Barbara Varenhorst and I served on a board together, along with a couple other colleagues in the counseling area. She asked me if I would be the guest at a Division E conversation hour at the 1984 annual meeting in Toronto; she was outgoing vice-president at that time. At this conversation hour I met Carl Thoresen and, one of his students at that time, Tom Coates. Tom wanted to talk with me about the possibility of a post-doctoral fellowship in our program on adolescence at the

Michael Reese Hospital Center and the University of Chicago. He was interested in learning more about adolescent development to complement his interventions into adolescent health behavior. He didn't take the post-doc but we began a series of discussions about adolescent interventions and adolescent development. What I learned from Carl, Tom, and their colleagues was very useful for my research on adolescence.

Information from counseling research became invaluable when I was asked by the chair of Obstetrics and Gynecology at Michael Reese to help them develop a program to reduce repeat pregnancy among adolescents. When I was initially asked to help with this very real problem, I decided that we first needed more information on the nature of the problem. (A typical researcher's response!) I obtained a small grant from the hospital research fund to study adolescent girls attending three hospital clinics: the Teen Family Planning Clinic (to sample contraceptors), the Obstetrics Clinic (to sample pregnant girls), and the Pediatrics Clinic, as a comparison. What I expected to find were differences in the demographic and psychosocial characteristics of the girls in the three groups. I had proposed that these characteristics could then be used to identify girls to be targeted for individual interventions because of their at-risk status. The modifiable attributes linked to having sex without using contraception, I proposed, could be the focus of the intervention.

What we found instead were no differences among the girls in either demographic characteristics or in attributes such as locus of control, cognitive ability, achievement motivation, self-esteem, or any of the other variables thought to place adolescent girls at risk for unwanted pregnancy. Instead the key variable seemed to be chance. These girls were playing Russian roulette with pregnancy and some were getting caught. For example, the average age at first pregnancy and the average age at first contraception use were very close, around age 15 in all three samples. Obviously these two events did not occur simultaneously for individual girls. Instead, what seemed to happen was that girls realized that they could become pregnant when a friend did. Their own reports corroborated this interpretation.

This left us with a dilemma in program design. What kind of an intervention would one design for all girls? This is where my counseling colleagues really helped. They had been running experimental interventions into smoking and other health behaviors with large groups of adolescents in schools. Our program would be hospital-based rather than school-based, but most features of their interventions seemed directly generalizable. A key to the Stanford programs was the use of a developmental principle as the basis for intervention design. They used knowledge about adolescent peer pressure, conformity to which peaks in early adolescence, to design interventions which used the peer group to reinforce the desired attitudes and behaviors. Since the peer group often plays a role in

reinforcing "unhealthy" behavior, researchers have reasoned that it could also be used to do the reverse. This peer model worked very well for our intervention into knowledge, attitudes, and behaviors linked to sexuality, contraceptive use, and childbearing. We manipulated knowledge, attitudes, and at least in-group behaviors through the use of positive peer group influence and techniques such as role play. My colleagues still at Michael Reese Hospital are just completing the long-term evaluation data but the preliminary results about efficacy have been very promising.

More importantly, the intervention provided basic information about the experience of these young adolescent girls at this stage of their development. For example we found a disjunction between the goals and expectations of these girls relative to their likely developmental outcomes; many of those for whom we would predict relatively poor outcomes had higher aspirations and expectations. They seemed to be naive about <u>how</u> to attain their goals, making attention to this process an appropriate focus for intervention.

Our discussions and collaborations led Tom Coates, Cheryl Perry, and I to organize a conference on adolescent health behavior, held at the Johns Hopkins University in the fall of 1980. We subtitled the conference, "Crossing the Barriers" to highlight the barriers that we felt existed among perspectives--including the developmental and counseling perspectives, among researchers studying different health behaviors, and between researchers and practitioners. There are many reasons for these barriers, many

involving facets beyond our control to change (e.g., different disciplines with different institutional entities, professional associations, and reward structures). What we thought we could influence, however, were assumptions and information held by professionals, whether researchers or practitioners. We felt that we had learned a great deal from each other and concluded that our experience could be generalized to others. The response to the conference and the subsequent edited book verified this to some extent. At least we took some beginning steps by sharing information about assumptions, perspectives, methods, and results.

Some examples of areas we focused on generally in the Conference were: (1) the goals of intervention and how these affect program design and (2) hypotheses about the development or etiology of behavior and how different hypotheses lead to different intervention models. If a goal of intervention involves encouraging postponement of a behavior, as with sexual intercourse for adolescents, the intervention might well differ from one in which the goal is to encourage adolescents to establish lifelong habits that forgo a behavior because it is unhealthy for everyone, as with smoking. Responsible use (or involvement with a behavior) is another possible goal, carrying implications for intervention that differ from those of the postponement or abstinence goals.

Social contexts are often implicated as factors in health behavior. The most common etiological hypothesis for adolescent health behavior involves the proximal influence of the peer group.

Parental influence is sometimes a focus. More recently, programs have focused on entire schools or communities. Each of these different intervention foci reflect, implicitly or explicitly, different hypotheses about etiology.

Another level of social context to be considered as explanatory is one I proposed in my presentation and chapter on adolescent sexual behavior. Social control exerted by the society at large is clearly implicated in the recent dramatic trends in increasing rates, and at earlier ages, of intercourse, especially marked among girls. Other individual-developmental (e.g., cognitive change, hormone influence) or social-contextual (e.g., peer group or family) factors cannot explain such short-term historical change.

Let me just mention a couple more areas where I have not yet collaborated with counseling colleagues but which seem like logical areas crying for such collaboration. One is adolescent eating disorders, especially those prevalent among girls, such as bulimia and anorexia nervosa. These problems are usually identified in clinical or counseling settings, yet I believe that especially bulimic behavior is normative in some groups in specific developmental periods (e.g., college freshmen). An integration of the counseling and human development perspectives would, I believe, lead to greater understanding of the problem and its treatment as well as of development at key times (e.g., transitions). An issue related to eating (and weight) is that of exercise and its effects

or development and well-being; collaborative research would be useful here as well.

A second area in which counseling/human development collaborations would yield especially fruitful results is that of adolescent stress and coping. This topic is of increasing interest to researchers, in part because of the evidence of problems during this age. We now know that not all adolescents experience the extreme tumult described by adolescent theorists such as Hall and Freud. Nevertheless, adolescence as a phase of life does appear to involve several normative stresses--pubertal change; school transitions from an elementary to a secondary school format involving dramatic changes in the structure of the school as well as demands on the students; both quantitative and qualitative cognitive changes; peer group structure, composition, and function; family structure and relationships. If these occur simultaneously with other stressful life events such as divorce or death of parents, illness, and so forth, unusual coping skills may be required to maintain "normal" growth and development. The issues involved with understanding stress and understanding coping skills require, in my opinion, the collaboration of researchers interested in development and in counseling or other interventions. The model here that I find useful includes two kinds of stress, normative or developmental stress and stressful life events. Developmental stress or "challenges" are specific to developmental periods. Stressful life events may have different effects at different ages. We need to

consider the individual's strengths and weaknesses prior to the stress as well as the individual's prior life circumstances such as family and peer supports. Problems are likely to result from overwhelming features of the environment, or weakness in the individual, or the interaction of both. Effective intervention must be based on knowledge of the characteristics of individuals at a particular age as well as the related key features of the important social contexts. We need to know both what happens "normally" in development as well as the ways in which and the means by which development can be enhanced through intervention.

Two developmental questions with respect to adolescents would be: (1) What happens with "naturally occurring" variations in the number and sources of stresses? Who is at risk? and (2) What kinds of coping skills do adolescents use and which seem to be more effective in the various kinds of situations? We need to consider those who do not succumb to stress as well as those who do. The "invulnerable" kids are an important group.

Parallel questions could be pursued from a counseling/intervention perspective. For example, what happens to the behavior and decision-making patterns of adolescents when they are placed in situations where the number and sources of stress are varied systematically? How can the coping skills of adolescents be enhanced? The latter question, for example, could start from and build upon information obtained from developmental studies about the most effective coping strategies. Here, the research on the

"invulnerable" and resilient children is useful. By trying to enhance coping skills, we could gain further information about how change can occur. In addition, we advance our overall goal of helping individuals to live more satisfying lives.

Summary

I have attempted, using the example of research on adolescence, to demonstrate the essential complementarity of counseling and human developmental approaches to understanding human experience. Although I recognize that both fields are about more than the study of change processes, I have focused on change as the primary aspect of human experience in which the two fields provide importantly interrelated, complementary information.

The counseling and human development approaches I have described differed primarily in research design. I could have used design terms to describe the differences, with experimental designs more typical of counseling research and nonexperimental designs more typical of human development research. (We know, of course, that both kinds of designs are used in both areas.) I have argued that information from experimentally-manipulated change designs provides information that supplements and complements the information obtained by "naturally-occurring" changes.

In some cases, however, a phenomenon cannot be experimentally manipulated and we can only have information from nonexperimental research. For example, it would be unethical to manipulate experimentally the time of onset of puberty, one of the key changes

during adolescence. Similarly, we ought not randomly assign children to one- versus two-parent families, or to families where the parents vary systematically in parenting skills. But, to focus on the latter example, we can use different means to attempt to change parenting skills, and then look at the effects of such change on developmental outcomes of the child.

What I am arguing, then, has two parts. First, I have been attempting to show that information from the two kinds of research is reciprocally informative. Second, in some cases at least, information from both sources is essential to really understand the phenomenon and, especially, to make a difference in the quality of human lives. If the goal of both counseling and human development is to help people live better, more satisfying lives, we need to work together both to understand what kinds of lives are satisfying, and how to create them.

To put the argument in another context, not only do I believe that Counseling and Human Development can coexist peacefully in Division E, I also believe that we must collaborate to attain our shared goal.

Implications of Argument for Division E Structure and Function

If we simply want to coexist peacefully, we could set up structures and functions within the Division so that each area's needs were met in a balanced way. If we believe that collaboration is necessary, then different tactics are required. We need to establish ways to communicate and share ideas. The Division can't

change your working environment at your home institutions, but we can expose you to ideas and people.

We have attempted to facilitate communication over the past two years in a few ways. First, by setting the theme for my vice-presidency of integrating counseling and human development, I hope I have at least planted the idea that this might be worth entertaining. Second, we have, especially this year in the program, tried to interject both perspectives into many programs. Like all good intervenors, we plan to evaluate the effectiveness of this attempt. Some sessions were designed particularly to establish dialogue. But much more could be done along these lines.

Helen Farmer, the Division's incoming vice-president, would like to establish a new journal for the Division, as a means to further the goal of integration. This would be an excellent way to facilitate communication about the two areas of research, and serve to foster further communication and perhaps collaboration.

The Newsletter could be used more to further the goal of integration. We could also sponsor workshops that involve techniques of interest to both fields. The possibility of an award for integrative research was mentioned yesterday at the business meeting. And I'm sure we could generate many other ideas. Let's try! I believe the rewards--for us as individual researchers, for the Division, for our respective fields, and for our common goal of enhancing human life--would make the efforts well worthwhile!